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ABSTRACT

Health care and social services in Poland are affected by the culture context of geography, demography, and culturally induced expansion in historical periods. Health and financing of health services are issues with significant political ramifications and, despite egalitarian ideology, there is differential access to care and services. The organization and administration of health care and services includes centralization of policy and financing, as well as regionalization of services. Private health care co-exists with the public sector. Health care data on Poland, as well as problems of health and nutrition, are discussed in this report. Also discussed are issues of health care, including meeting basic needs, maldistribution, physician imbalance, and operational and supply problems. (Author/JD)

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HEALTH CARE AND SOCIAL SERVICES IN THE PEOPLES REPUBLIC OF POLAND

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HEALTH CARE AND SOCIAL SERVICES IN THE PEOPLES REPUBLIC OF POLAND

PART I CULTURE CONTEXT

1. GEOGRAPHY AND DEMOGRAPHY

Poland covers an area of 312627 km and has a population of 36 million. Poland is administratively divided into 49 voivodships (provinces), which includes three large cities treated as separate units. Each voivodship is divided into cities and communities; 808 cities and 2138 communities. In 1977, Warsaw the capital had over 1.5 million people. Approximately 55% of the Polish population live in urban areas. The birth rate in 1977 was 19.1%, the death rate, 9%. The annual rate of population increase was 10.1%.

The proportions of various age groups in the population in 1977 was:

0-14 years 8312000 (23.9%)
15-64 years 23040000 (66.1%)
65-74 years 2371000 (6.8%)
75 and over 1122000 (3.2%)

(WHO, 227)

Poland is a homogenous society in religion and sociocultural background and has a nationalized health system. Distribution of health resources therefore does not pose the same type of problem as more complex societies. Of its population, "Poland is characterized by a devoted nationalism, a

population with continued interest in its Catholic Church, and increased assertion of its distinctness and identity. Following the wartime annihilation of Poland's Jews and subsequent population transfers and annexations in postwar boundary "adjustments," Poland is now ethnically almost completely homogeneous in contrast to the prewar years when 30 percent of the population consisted of ethnic minorities." (Kahn, 41) Poland current population is 98% Catholic and the literacy rate for adults is 98% as well. It is under Communist Party control, the United Workers Party, and a Soviet satellite due to geographic proximity.

With the advent of the Communist state and control by the United Workers Party in 1945, after World War II, a new socioeconomic policy stimulated development of industry and the socio-economic reconstruction of Poland. One of the main objectives of the new social policy was to develop the national health service to be available for the whole population. (Roemer, 155)

1.2 HISTORICAL MARKERS FOR EXPANSION OF HEALTH SERVICES

Key position markers for expansion of health services and health manpower development are (Kostrzewski)

POLITICAL - 1945 - LIBERATION OF POLAND

1. 1945 -- Ministry of Health appointed as superior body responsible for organization and administration of national health services;

2. 1951 -- Medical and Pharmaceutical Faculties become Medical Academies under the administration of the Minister of Health. Medical schools for nurses, midwives, sanitary instructors, and allied health personnel placed under supervision of the Ministry of Health;

POLITICAL - 1953 - DEATH OF JOSEPH STALIN

3. 1954 -- Sanitary epidemiological services organized and State Sanitary Inspection Act passed;

POLITICAL - 1956 - WLADYSLAW GOMULKA ELECTED AS FIRST SECRETARY OF THE COMMUNIST PARTY (LIBERALIZATION) - POZNAN WORKER RIOTS

4. 1956 -- Industrial health service organized;

5. 1960 -- Minister of Health and Social Welfare appointed and charged with the administration of social welfare as well as rehabilitation and employment of invalids;

POLITICAL - 1970 - COLLAPSE OF GOMULKA GDANSK FOOD RIOTS - EDWARD GIEREK BECOMES PARTY SECRETARY

6. 1971 -- Medical care and medical aid made available free of charge for the entire population, including the rural population previously not covered by health insurance system. (Kostrzewski,)

1978 - SOLIDARITY EMERGES

POLITICAL - Dec. 1981 - GENERAL JARUZELSKI DECLARES MARTIAL LAW

1.3 FINANCING

FINANCING AND DELIVERY OF SOCIAL AND HEALTH SERVICES

"Most service delivery is by community authorities at the local level, the latter financed by the central government (55 percent) and locally by taxing industry (45 percent). At each level an elected People's Council, its members holding four-year terms, is the governing unit, but the functions exercised are subject to the higher levels in a hierarchical structure leading to the Sejim (Parliament) and the Council of Ministers." (Kahn, 41) Party control is powerful, and the administrative apparatus is extremely influential in decision-making.

1.4 HEALTH AS A POLITICAL ISSUE

A major health policy issue deals with the issue of freedom and control in a communist society. (Webster, 309)

> How to allow for personal choice and initiative within a system that attempts to ensure the distribution of health care for all. Furthermore, year-to-year policies that are politically and economically sensitive may or may not mesh with longer-range planning and development that is presumably geared more to health-science data and trends. Economic factors often become overriding in any case... Intense issues of freedom and initiative flared under Solidarity's demands on central planning and control, and the flame was fanned by economic desperation.

The political factor of freedom and control plays itself out in other nations as well. Certainly in the United States, health policy decisions and actual health operations are not based exclusively on scientific and humane considerations, although our ideology suggests that we have the greatest good for the greatest number. "By contrast, in socialist countries, the preeminent importance of politics in policy formulation on the health care system and virtually all other aspects of life is openly and repeatedly emphasized. The priority of political considerations is, itself, a major principle in socialist thinking." (Roemer, 153)

Health as a political issue is clearly reflected in the activities of Solidarity, the former independent labor union, to extend health services. Close colleagues of Lech Walesa raised health-care issues in the flush of Solidarity's earliest negotiations with the government. Alina Pienkowska, who was a nurse and activist in the Gdansk shipyards, became the chief of Solidarity's Health Section. Despite a heavy debt of over 27 billion to Western creditors (Webster, 309-10)

> ... under Solidarity's stimulation, the government committed itself to its largest increase for health care: from 5 per cent to 6 per cent of the falling gross national product. The union negotiated agreements for salaries, hospitals, equipment, and other improvements, which were heaped on an already strained economy. (Webster, 309)

Solidarity became very active as an advocate in health service expansion. Its political freedom advocacy (Webster, 311-12)

> ... extended to health services, hospitals, clinics, medical academies, research, and health-professional organizations. Its advisory committee of health experts,

with the energetic Alina Pienkowska as chairperson, participated in vigorous discussions with government representatives that were based on a 1980 list of health issues that the unionists had drawn up. These issues included adequate primary health care; better training for young physicians not located near hospital centers; solutions to drug shortages; improved training and services for alcoholism; increased research, especially in work-related diseases; more continuing education for physicians and other health personnel; and a larger share of the gross national product.

Solidarity also demanded increased capital investments for construction and equipment, improved sanitary conditions in health facilities, more social services, more blood donors and equipment, improved transportation for patients, and more available prostheses.

In November 1980, Solidarity health advocates became the first Solidarity group to occupy government quarters as a strategy in negotiations. After two weeks of the sit-in, they won agreement on several issues.

On August 31, 1980, as a result of the Gdansk shipyard strike, the Polish government signed a 21 point agreement with Solidarity, the Free Trade Union. Point 16 which focuses on health, is an expression of health needs and concerns in 1980 Poland, that Solidarity addressed, and which the government at that time, accepted. The issues were mainly those of working conditions and status improvements for health care services as well. The agreement reads, (Mcshane, 157-158)

Point No. 16,

"To improve working conditions and the health services so as to ensure better medical protection for the workers", it has been agreed that: It is necessary to increase immediately the resources put into the sphere of the health services, to improve medical supplies through the import of basic materials where these are lacking, to increase the salaries of all health workers, and with the utmost urgency on the part of the government and the ministries, to prepare programmes for improving the health of the population... measures to be taken in this area are ...:

1. To introduce a "Charter of Rights for Health Service Employees".
2. To guarantee supplies for sale of an adequate amount of protective cotton clothing. (CLOTHING)
3. To refund health service workers for the purchase of work clothes from the material expenditure fund. (CLOTHING)
4. To provide a guaranteed wage fund that would make possible rewarding all those who have performed outstanding work in accordance with the theoretically existing possibilities. (MERIT PAY)
5. To set up funds for additional payments upon the completion of 25 and 30 years of work. (INCREASED PAY)
6. To establish additional payment for work under difficult or harmful working conditions, and to introduce additional pay for shift work by non-medical employees. (HAZARD DUTY PAY)
7. To restore additional payment to those attending patients with infectious diseases or to those handling contagious biolcgical material and to increase pay for nurses on night duty. (HAZARD DUTY PAY)
8. To recognize spinal diseases as occupational for dentists. (OCCUPATIONAL DISEASES)
9. Allocation of good quality fuel to hospitals and nurseries. (HOSPITAL SUPPLIES)
10. To recognise additional payment for years of service to nurses without secondary school diplomas, to bring them up to the earnings level of graduate nurses. (INCREASED PAY)
11. To introduce a seven-hour work day for all skilled workers. (SHORTER HOURS)
12. To introduce free Saturdays without the requirement of making up the time otherwise. (LESS HOURS)
13. Sunday and holiday duties to be paid by a 100 per cent increase in wages. (OVERTIME)
14. Making medicine available free of charge to health service workers. (FRINGE BENEFITS)
15. Making it possible to make a partial refund of housing loans from the social fund. (FRINGE BENEFITS)

16. To increase the allocated apartment space for health service workers. (FRINGE BENEFITS)
17. To make it easier for nurses living alone to be allotted apartments. (FRINGE)
18. To change the award fund into a 13th monthly salary. (FRINGE)
19. To give a six-week vacation to health service workers after 20 years of service and to make it possible for them to receive an annual paid vacation for health reasons, as is enjoyed by teachers. (FRINGE)
20. To give people working for their M.D.'s four-week vacations and those working for specialised degrees two-week vacations. (FRINGE)
21. To guarantee a doctor the right to a day off after night duty. (SHORTER HOURS)
22. To give workers in nurseries and kindergartens a five-hour schedule, as well as free board. (FRINGE)
23. To introduce allocation of cars for basic health service workers and a mileage limit or a lump sum refund for business travel. (FRINGE)
24. Nurses with higher education should be recognised and paid the same as other workers with a higher education. (STATUS)
25. To create specially trained repair groups in the ZOZs (factory health centres) to protect health service buildings from further deterioration. (MAINTENANCE)
26. To increase the per capita standard allowance for medicines for hospital patients from 1,138 loty to 2,700 zloty, since the latter is the actual cost of treatment, and to increase the nutrition allowance as well. (HEALTH SERVICES)
27. To set up a system of food vouchers for the bedridden. (HEALTH SERVICES)
28. To double the number of ambulances - this being a real need today. (HEALTH SERVICES)
29. To take steps to guarantee purity of air, soil and water, especially coastal seawater. (HEALTH SERVICES)
30. Along with being provided with new housing developments, citizens must also be provided with health centres, drug-stores and nurseries. (HEALTH SERVICES)

Solidarity's pressure for reforms and self-organization impacted the personnel in the health field or well. Doctors, medical students, and health professionals organized to advance their perspectives and interests. (Webster, 312)

> Before Solidarity, physicians as an organized group had not been highly active or influential - reportedly by decree - since the postwar government had been established. Over the years, individual physicians and scientists have participated in expert advisory committees of the government, and top officials in the Ministry of Health and Social Welfare and some members of the parliament have been physicians. In 1981, organized protests by medical students led to the dropping of a long-established course on "politics for the physician" (mainly Marxism) from the required curriculum. When and if the country returns to civil rule, the recently more active physicians' association may be allowed a greater voice in health-policy

> deliberations. On the other hand, the blossoming of self-organization, seen also among other professions in 1981, may not be permitted to continue.

A change took place in the political climate by 1982. Heavier authority was imposed throughout the health system. "Self organization" among health personnel, inspired by Solidarity, was replaced by a top down authority. Fifteen supervisors, appointed by the Ministry of Health are now assigned to a three-province region, to expedite previously determined national and local health priorities (Webster, 903)

Reflecting this earlier intellectual trend for greater freedom of expression was the movement toward greater freedom, but for the mentally ill, not healthy population.

In an 1978 article by Stanislaw Dabrowski, Director of the Psychoneurological Institute of Warsaw, he deals with legislative draft proposals for mental health care in Poland. The article does not refer to political issues of health but the questions of freedom and free choice raised with mental health cases have application value for the general population as well. The issue focuses an individual rights of mentally ill persons as opposed to involuntary commitment. The draft legislative proposals in 1978 were: (Dabrowski, 125)

> 1. The Principle of Self-Determination which requires the patient's (or his legal representative's) consent for all examinations, treatments, rehabilitation, and care. Specific consent is required for certain types of treatment such as surgical operations or other therapeutic modalities known to entail an above-average risk...

2. The Principle of Informed Consent is an essential complement of the preceding principle. The physician is therefore required to inform the patient (and/or his legal representative) about the purpose and expected results of any therapeutic procedure. The Draft Proposal, however, does foresee the possibility of exempting the physician from any responsibility to convey such information if that action could have antitherapeutic consequences for the patient.

3. The Principle of Free Contact and Correspondence assures the patient a right to communicate with his family and others. The written correspondence of patients is therefore exempt from hospital censorship.

4. The Principle of Respect for the Whole of a Patient's Needs (within the treatment process) provides that health goals cannot be reached at all costs, for instance, at the expense of other personal (e.g., moral, intellectual and professional) needs of the patient.

It is clear from the above proposals that issues of freedom debated for the mentally ill, are not too distant from issues of political concern for the general population.

POLITICAL PRESSURES ON PHYSICIANS

A number of Polish physicians came under government pressure during the Solidarity activity and Martial law periods. In an open letter to General Jaruzelski dated Feb. 12, 1982, a number of Polish physicians lodged a protest about the inadequate medical care of political prisoners in isolation camps and prisons. In April 1982, military authorities in Poland showed an interest in the possibility of psychiatric interment for political prisoners. Dr. T. Zielinski, Director of the Nowowiejski Psychiatric Hospital denied this political request. (Niewiaroski, 290)

A number of Doctors were close to the Solidarity movement and helped provide Solidarity members with needed medical care. Also, there were a number of Doctors arrested for political activity, and for guilt by association. An underground Solidarity weekly Mazowsze noted in October 1982 that a number of physicians had been fired in Weyherowo Hospital because they had been too helpful to internees. On October 28, 1982, of the 6,000 internees and political prisoners in Poland, close to 100 were detained physicians and member of the allied health profession (Niewiarowski, 290) By 1982, in the medical school curriculum, the political science course on Marxism has been reinstituted, and military medicine has been allocated more curriculum time. (In 1981, after medical student protests, the Political Science course had been dropped) (Webster, 903)

SOCIO-ECONOMIC CLASS AND DIFFERENTIAL ACCESS TO CARE IN POLAND (1982)

Salkever did research on the relationship between economic class and access to health care in five countries. Canada, England, Finland, the United States, and Poland. He concluded that in all of these nations, "... higher family income is associated with greater access to medical care among children at all levels of need." (Salkever, 373)

He suggested a socio-economic differentiation of service for children unrelated to the ideological structure. He notes what could be considered a theory of convergence based on common problems of industrial society (Salkever, 390)

> Overall, the results of this illustrative empirical analysis are somewhat surprising. They do not strongly support some widely held notions concerning the relationship of health system structure to access differentials, such as that accessibility will be more closely and positively related to economic class in market-oriented systems than in non-market systems. What is particularly striking, in this regard, is the persistence of large access differentials among children regardless of system structure (and that) ... low-income children enjoy considerably less access to care than high-income children regardless of health care system structure.

On the Polish scene, Anna Titkow, a medical sociologist, did a study in Warsaw. On the basis of this study she noted that the influence of income and education made itself felt on various forms of health care behavior. She concluded that, "the galitarianism assumed in the model of the Polish health service is decisively modified by the existing structure of inequality." (Taylor, 294)

Although Poland is a Socialist society, class factors impact the availability and utilization of health services. The educated classes evidently are able to benefit more from the system. As noted, (Ostrowska, 634)

> A comparison of waiting times shows a certain non-egalitarianism as far as the physician's availability is concerned. If we compare the extreme categories of patients waiting usually for the shortest time (<30 min) and patients with the longest waiting time (about 3 hr.) it turns out that the former include a bigger number of white collar workers and the intelligentsia, while the latter consists of unskilled workers. Since it considers the same outpatient clinics, near to the respondents' places of living, these are not the differences between the 'better' and 'worse' outpatient clinics. In the very same outpatient clinic it is much easier for the people with a higher social status to overcome all the bureaucratic and administrative barriers before entering the doctor's room; therefore, they are promptly seen to and in a much more satisfying way, as further data will show. As we can see, the socialist health care system was not able to dismiss those inequalities, which are against its egalitarian principles.

PART II - ORGANIZATION

2.1 ORGANIZATION OF HEALTH SERVICES IN HISTORICAL PERSPECTIVE

In Poland there has been a development of a centralized system of health with some periodic focus on decentralized integration of service as a characteristic Polish society.

Between 1946-1960, a tendency towards vertical centralization prevailed in the organization and administration of the health services. (Roemer, 155-156)

> A basic principle of the United Workers Party was to develop a unified health care system, with major policy decisions made... at the national center. The implementation of policy would be at the level of the provinces... The unification of the system, with the objectives of efficiency and effectiveness, meant that at the top all health services would come under the direction of a single Ministry of Health and Social Welfare. Thus, unlike in Western European countries, the social insurance program which financed most medical costs was not under a different ministry, and the hospitals did not remain under the control of local government. All health service resources, whether fiscal or professional, preventive or curative, institutional or ambulatory, were placed under one central ministry. Each province would have a Department of Public Health, with equivalent broad responsibilities, reporting to the central Ministry.
>
> Unified administration applied... also to the distribution of drugs through public pharmacies, the training of doctors and all "middle medical" or allied health personnel. By 1952, the faculties of medicine, pharmacy, and dentistry were withdrawn from the universities - under the Ministry of Higher Education - and put in separate "medical academies" under the control of the Ministry of Health. Thus, health manpower development (was to meet) the health service needs of the population (and) the surveillance of quality in the health services could be best conducted by the medical faculties when these were fully integrated into the health care system... Likewise, research was to be directed primarily to health problems of greatest importance in the population - rather than of greatest personal interest to the scientist - and was developed principally in fourteen "national research institutes" under the Ministry of Health.

After 1960, decentralization dominated, with a tendency to integrate health services with the social services, especially at the provincial and county levels and, more recently, in the form of the integrated health service institutions at the local level. (Kostrzewski, J.N.P.)

2.2 ORGANIZATION OF POLISH HEALTH CARE: CENTRALIZATION AND REGIONALIZATION

In the 1970's, Polish health care again moved toward centralization and integration of services while retraining or developing special organizational structures for occupational health (Wloudarczyk, 625)

> A special feature of the Polish health care system in the 70s was the process toward organizational centralization. This consisted in integrating independent organizational units into larger, more complex ones, and transferring the process of decision-making to higher management levels. This transition was introduced in 1975. One of its effects was incorporating into one organization all health care systems in a given area, primary care hospitals, specialist care units, laboratory bases, emergency and social welfare agencies and subsuming all these institutions under one management. The ensuing organization was named the Health Care Complex (HCC). It is interesting that in the HCC area other organizations were founded to cover industrial workers. These were called Occupational Health Care Complexes (OHCC) and there were a variety of these occupational health agencies.

Centralization however did not resolve the problems and often, "meant a deterioration in hospital conditions, as both administration and centralized diagnostic facilities occupied already overcrowded space. There was widespread feeling that the model statute for the new structure was applied with no regard to variations in local conditions and with unnecessary proliferation of administrative posts."(Millard, 509)

In 1975, the Polish health system was reorganized into health provinces, districts and zones. By 1978, there were(Taylor, 293)

> ... health provinces; within each province there are health districts containing from 50-250 thousand patients; and within each district there are health zones containing from 3-6 thousand patients. In most urban areas the primary needs of patients within each health zone are met by a health care team which includes a general practitioner; pediatrician, dentist and obstetrician/gynaecologist. In rural areas, which were only incorporated into the national health service in 1971, the general practitioner normally works alone. An industrial health service, a national T.B. service, university medical schools and medical research institutes are organised centrally, and they operate independently of this three-tiered structure. The system is further complicated by the existence of private practice and doctor's cooperatives. Current problems in the functioning of the health service include overcentralisation on Warsaw, a high rate of referral to specialists, over-use of emergency services and an over-concentration of medical manpower in the hospital sector.

In essence, there is a four tier organization in Polish health services which facilitates distribution of services and resources National, province, district and local health care units (Webster, 310)

> At the national level, the Polish ministries and institutes collaborated in planning for education and services and in sponsoring research; each of the 49 provinces (voivodships) had a relatively self-contained health system; district health-care complexes integrated hospitals, most inpatient and outpatient specialty services, social services, and administration of local health-care units; and health-care units provided primary care and preventive services, each serving 3000 to 5000 people. These units were usually staffed by four doctors: an internist or general practitioner, a pediatrician, an obstetrician-gynecologist, and a dentist; in some rural areas, the unit was staffed by a single general practitioner. Poland's 10 medical schools (academies) were integrated with the health-care system, usually at the district level and sometimes at the province level. Factories and other institutions provided a parallel system of complete health services for over 6.3 million workers.

Although this four tier system is in existence, decision-making is primarily top-down and the different tiers serve as a conduit for top-down policy. The norms of the central system clearly prevail in the sy stem (Webster, 312)

> The administrators of health programs at province, district, and local levels described a very limited role in financial planning. Program plans and requests were passed upward through the echelons without projected operating budgets.
>
> As one Polish health economist told me, "Budgets are dispensed downward. The financing determines the program."

> The zlotys alloted were attached to "norms" such as number of bed-days, which were the bases for planning programs. Salaries were a separate budget item, and capital "investments" for equipment and construction were centrally administered outside the ministry's operating budget for health care. It was difficult for health-program administrators to follow rates and trends in the efficiency and effectiveness of component costs and services. This had the effect of making control of expenditures the primary consideration, according to my informants. Rather than what was done with the money or whether the money could have been used in a better way, the question was whether the program fit the norms.

REGIONALIZATION

The 1980 reforms focused on the ZOZ a basic organizational unit which was supposed to correct the fragmentation in the Area Health Complex (Millard, 508)

> One ZOZ serves from 30,000 to 150,000 inhabitants, a territorial area embracing a number of rural communes (gminy) and one (or sometimes more) towns. Generally the ZOZ directorate is located in the main ZOZ general hospital, along with the main economic and administrative support services. The specialist care division is also hospital-centered, although in addition to hospital wards, emergency services, and outpatient clinics, it also embraces a variety of specialist polyclinics situated outside the hospital terrain itself.
>
> Each ZOZ is divided into urban and rural districts (rejony) providing, in theory, primary care for approximately 3000 to 6000 inhabitants. There are three main types of primary care facilities: urban, rural, and occupational. Primary care, however, is widely conceived; it includes not only general medicine but also pediatrics, gynecology-obstetrics, dentistry, and (in the occupational clinics) industrial medicine as well.

> The ZOZ, then, was conceived as a complex, integrated structure. The previous fragmentation of the health service, with separate structures for "closed" (hospital) and "open" health care, had generated profound inefficiencies in the system, now to be resolved by the process of integration. However, the community ZOZ does not embrace the entire population. Areas of high industrial concentration have their own industrial ZOZs; with or without a hospital.

The ZOZ forges closer links ... "between primary care centers, polyclinics, and district hospitals in local "integrated health service areas" which vary from about three to ten per province. For historical reasons, the purely environmental, epidemiological, and health educational services are operated by a parallel local network of "Sanepid" stations, that are integrated with the personal health care system only at the provincial and national levels. (Roemer, 157)

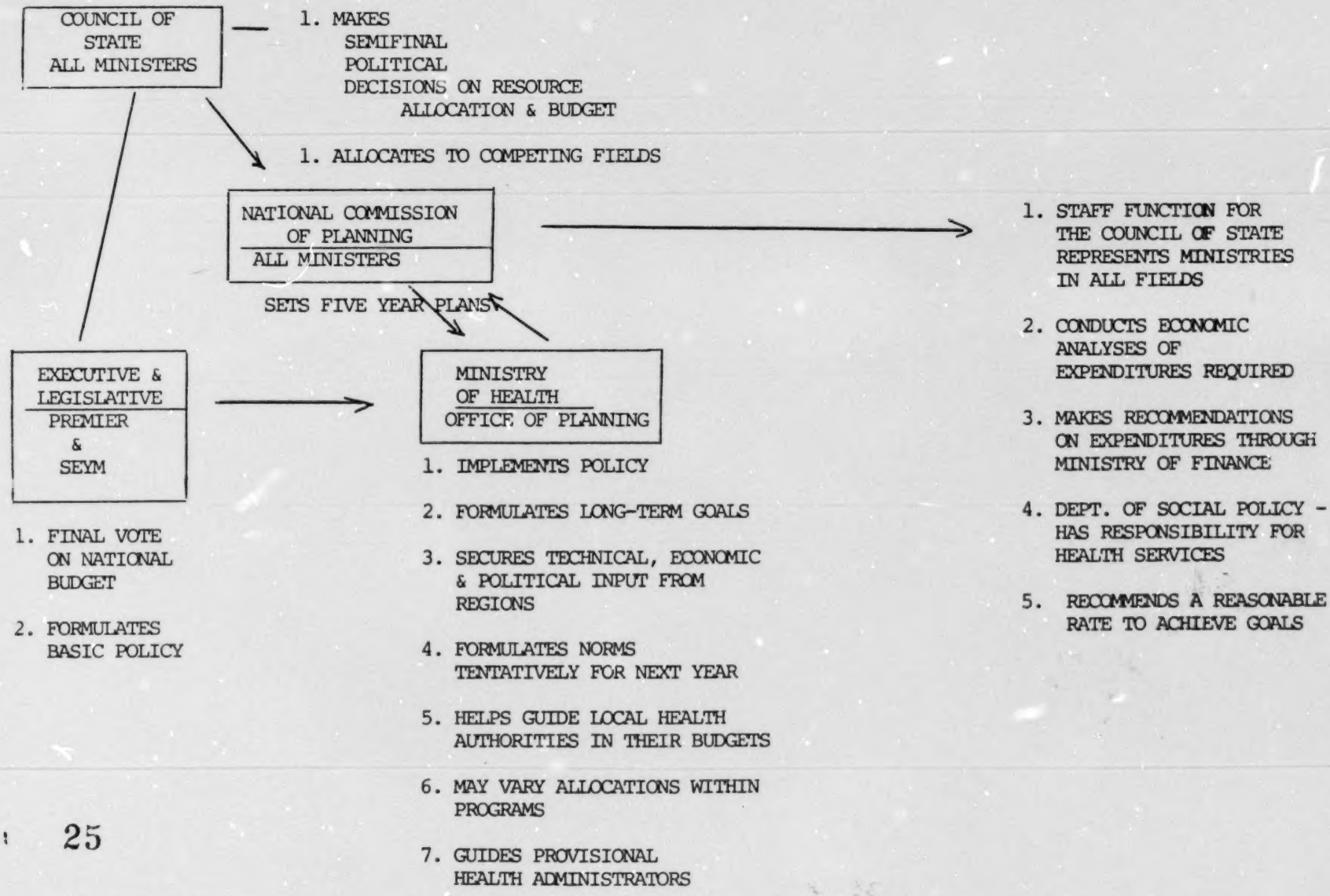
All health workers in the ZOZ are public employees. However, by 1982, the introduction of the ZOZ had not resolved the problem of a needed integration of access, continuity and complexity of care. (Millard, 509)

> It did not break down the barriers between the primary care, polyclinic, and hospital elements. The intended movement of personnel from one to another remained largely illusory. Indeed, the integration of the health service made the system even more hospital-centered than before. The hospital is the administrative center of the ZOZ, the director and his/her deputies are almost always doctors, and the deputies often function simultaneously as hospital ward chiefs (ordynatorzy). The hospital is also the largest spender in the ZOZ budget and as such attracts disproportionate attention. Finally, the provincial physician (the director of the provincial Health Department,) the ZOZ superior, has various advisory bodies that are dominated by hospital-oriented clinicians.

In 1978, the policy formulation process represented an attempt to have both centralization and local integration. A model (See following page) developed on the basis of Rochmer (155-162) follows:

CENTRALIZED HEALTH POLICY FORMULATION IN POLAND

(Based on Roemer description, p. 155-162)


COUNCIL OF STATE
ALL MINISTERS
1. MAKES SEMIFINAL POLITICAL DECISIONS ON RESOURCE ALLOCATION & BUDGET
1. ALLOCATES TO COMPETING FIELDS
NATIONAL COMMISSION OF PLANNING
ALL MINISTERS
SETS FIVE YEAR PLANS
1. STAFF FUNCTION FOR THE COUNCIL OF STATE REPRESENTS MINISTRIES IN ALL FIELDS
2. CONDUCTS ECONOMIC ANALYSES OF EXPENDITURES REQUIRED
3. MAKES RECOMMENDATIONS ON EXPENDITURES THROUGH MINISTRY OF FINANCE
4. DEPT. OF SOCIAL POLICY - HAS RESPONSIBILITY FOR HEALTH SERVICES
5. RECOMMENDS A REASONABLE RATE TO ACHIEVE GOALS
EXECUTIVE & LEGISLATIVE
PREMIER & SEYM
1. FINAL VOTE ON NATIONAL BUDGET
2. FORMULATES BASIC POLICY
MINISTRY OF HEALTH
OFFICE OF PLANNING
1. IMPLEMENTS POLICY
2. FORMULATES LONG-TERM GOALS
3. SECURES TECHNICAL, ECONOMIC & POLITICAL INPUT FROM REGIONS
4. FORMULATES NORMS TENTATIVELY FOR NEXT YEAR
5. HELPS GUIDE LOCAL HEALTH AUTHORITIES IN THEIR BUDGETS
6. MAY VARY ALLOCATIONS WITHIN PROGRAMS
7. GUIDES PROVISIONAL HEALTH ADMINISTRATORS

ENERALIZATIONS

: System is centralized with local input

: Political factors are central control of decision-making

2.4 PRIVATE AND PUBLIC HEALTH CARE

Both public and private care exist in Poland with different means for entry into these systems, and different staffing organizations. (Roemer,15?)

> The principal physical resources for health care delivery in Poland are nationwide networks of ambulatory care centers and hospitals, staffed entirely by salaried medical and allied personnel. Entry of any patient into the system, for either treatment or preventive service, is through the primary care center in his neighborhood. These units are staffed normally by teams of a general physician (sometimes an internist), a pediatrician, an obstetrician-gynecologist, and a dentist, plus nurses, technicians, clerks, and other middle medical workers. (In isolated rural areas, the core staff may simply be a generalist and nurse.) Referrals, when necessary, are made to a polyclinic with more specialized personnel or to a hospital at the local district or central provincial level, depending on the severity of the case.

Private practice exists as well in Poland, and takes two forms,(Roemer,15?)

> ... as individual practice or "medical cooperatives" (which we might call group practice clinics). The latter are rather tightly regulated by the provincial departments of health as to the fees chargeable, conditions of work (two hours per day maximum per doctor) and so on. It is estimated that about twenty percent of ambulatory services in Poland are currently obtained at personal expense through these private arrangements, so that the national goal has not yet been reached. Hospitalization, however, is exclusively public.

2.5 A UNIQUE CONCEPT OF INSTITUTIONAL INTEGRATION

In 1976 Poland social services were viewed as buttressing the more primary institutions and helping the individuals understress to cope and adopt within the context of traditional institutions of school, health faculty, workplace, family and church. The concept of "residual social welfare" formulated by Wilensky and Lebeaux rejects the alternative of developing new primary institutions to deliver social services (Kahn, 325)

As Kahn notes,

> The basic pattern, is that one social sector institution carries major responsibility at each life stage. For the first three years of life there is the health system; then the educational system takes over until one is ready for the world of work. For most of the life span, it is the labor ministry which plays the central role. (Labor union-based social services are important, but mostly for "utilities.") The health ministry resumes its role in the postretirement years. The central ministry for each life stage organizes essential services and brings in needed professionals from other disciplines; thus day care programs, or children's institutions and shelters for children during the first three years of life, are under health authorities. Programs for dealing with delinquents during the school years are largely under educational auspices. Special social services for senior citizens are the responsibility of a social welfare department in the Ministry of Health and Social Welfare, but the needed professions take part. . .
>
> The social services become adjuncts to the central are not a freestanding system and do not attempt a coverage structure of their own for local delivery. They play the role of secondary profession in the host institutions Just as day care facilities for under-3s bring in educators, and educational authorities hire experts in institutional care of difficult children, so do authorities bring in social work personnel to play specific ancillary roles in health, education, labor, and income-security agencies.

2.6 KEY HEALTH SERVICE PRINCIPLES IN POLAND

There are a number of organizational principles, characteristic of Polish health, that have value for possible use in the U.S.A. (Roemer, 161)

> (1) The integrated delivery of primary health care, preventive and therapeutic, is effective and economical. Every person, adult and child, has access to a primary physician near his home, and necessary referrals are then made as needed.
>
> (2) Continuing education of doctors and other health personnel is so widely and sy stematically provided, with incentives offered for participation, that nearly every health care provider is stimulated to keep abreast of his or her field. Educational institutions, being within the health service establishment, offer such education, along with quality surveillance of services, as part of their regular functions.
>
> (3) With specialists, as well as all other doctors, paid by salaries - varying in accordance with their training, competence, and responsibility - both in polyclinics and hospitals, there are no incentives for unwarranted surgical operations or other excessive and costly services. Yet, since all doctors work in teams, there is daily "peer review" built into the system (rather than onerous and post-hoc review by Professional Standard Review Organizations) to protect patients against perfunctory care. This pattern of organized in-hospital specialty service, incidentally, is not unique to Poland, but characterizes most Western European nations as well.

(4) With the majority of all Polish doctors being devoted to primary care, there is no need for doctor-substitutes of limited training to carry out this crucial function.

Existing Feldshers (Physician's assistants from the post-war period have been converted to, "... serve as sanitary inspectors, ambulance attendants, health educators, nurses, or other true health auxiliaries, and the brighter among them were encouraged to attend medical school and become physicians.

(5) Health services are regarded as a public benefit to which everyone is entitled without charge. The main limitation is the nation's capacity to produce personnel and facilities to meet the needs. Yet a private sector has never been banned and a certain degree of inequity, based on an individual's ability to pay, will be permitted until the public services are strengthened further. This strengthening is guided by judgments on the relative needs of different sectors in the total society, and not by the dynamics of individual self-interest, more politely designated as "the free market." (Roemer, 161)

2.7 PHYSICAL REHABILITATION AS PART OF HEALTH CARE SERVICES

There are 435 Invalid's Cooperatives throughout Poland, members of the Invalids' Cooperatives Union, head organization of all the cooperatives. (Geist, 63) These cooperatives are industries managed operated and staffed primarily by disabled workers. The cooperatives, which include a sheltered workshop, produces goods and sometimes gets involved in the design and sales of the same goods. To be designated an Invalid's Cooperative, a cooperative must have at least 70% of its employees as disabled. The state allows a tax exemption based on the number of disabled employees, and this tax exemption money can then be used to provide special services or supplies needed by the invalid members. The Invalid's Cooperatives Union, operates vocational schools for disabled children, and runs medical rehabilitation centers and patient care facilities in app. 400 of the cooperatives, with a staff which includes a physician, physical therapist, nurse, social worker and recreational therapist. Many cooperatives have laboratory facilities and also focus on improving conditions for the handicapped such as job modification, improvement of housing, elimination of architectural barriers and provision of medical rehabilitation during job-time for workers. 90% of the cooperatives are located in urban areas and employ 274,000 workers of whom 203,000 are disabled, of these disabled, 40,000 are involved in homebound programs. (Geist, 63-65 passim.)

PART III - INDIVIDUAL HEALTH CARE

3.1 HEALTH CARE DATA FOR POLAND, COMPARED WITH THAT OF THE U.S.A.

There has been a great deal of progress in the health of the population and health care services since 1945 the period after W. W. II to 1980. (Webster, 1982, 309)

> Poland, with its policy of free health care for all, has succeeded to a remarkable degree in distributing its scarce resources to improve the health of its people. The physician-to-population ratio grew more than fivefold in 30 years, from 3.7 physicians per 10,000 population in 1950 to 19.3 at present. (The United States ratio increased from 14.2 to 19.7 from 1950 to 1980). Care of mothers and children was given a high priority and reached over 90 per cent of the nation's children through a system of case registries and active follow-up for routine medical checkups through the age of 18. Infant mortality fell dramatically from 111.2 deaths per thousand live births in 1950 to 24.5 in 1977. (The United States rate was 24.7 in 1965 and 14.1 in 1977.) Poland's birth rate, death rate, life expectancy, and percentage of population 65 years or older were comparable to those of the United States by 1980.
>
> This progress was achieved with a smaller health-related share of a much lower gross national product than that of the United States. The Polish gross national product was $2,860 per capita in 1976, when that of the United States was $7,890 per capita expenditures on health care were about $50 (1,650 zlotys), as compared with $1,067 in the United States. Behind this striking contrast, I learned, were wide differences in salaries and standards of living between the two countries and the steady decline in the zloty's monetary exchange value. Styles of medical practice and expectations about health care differ. Elective surgery, technology, and expensive medical procedures were much less available in Poland. Central control had helped to direct health programs into priority areas and hold down costs, as had the chronic shortages of drugs, equipment, and supplies. Nonetheless, impressive gains were made in Poland's health, with relatively low national expenditures.

In the 1980 WHO report the following 1977 information about Polish health.

(1) (HEALTH PROBLEMS IN A MODERNIZING ECONOMY)
The main health problems are cardiovascular diseases, diseases, diseases of the respiratory tract and alimentary system, cancer and mental diseases and diseases of the nervous system. (WHO, 228)

(2) (DEATH RATES FOR A MODERNIZING ECONOMY)
... The death rates for cardiovascular diseases and malignant tumours have increased; 44% of deaths are caused by cardiovascular diseases and 23% by cancer. Accidents, traumas and poisonings are also increasing and in 1976 caused 8% of deaths. The death rate for infectious diseases and respiratory tract diseases fell significantly (1.7 and 5.4 per 10000 respectively). Out of the total of 670,000 deliveries there were only 95 maternal deaths caused by complications. (WHO, 228)

By 1982 the increase in aged population was resulting in an increased incidence of coronary disease. Also, greater stress among administration and managers, and cigarette smoking, hypertension, obesity and alcoholism among the general population are reflected in 70,000 new cases of myocardial infraction recorded in one year 194 per 100,000 population - three times more frequent in males. (in 1979, the Polish diet contained approximately 38% animal fat) (Webster, 904)

(3) (TUBERCULOSIS CONTROL)
Enormous progress has been made in tuberculosis control. The number of new cases decreased to 24,700 in 1976, the most significant decrease being observed among children and adolescents. (WHO, 228)

(4) (HEALTH STATUS OF INDUSTRIAL WORKERS)
...The health status of the industrial workers does not differ very significantly from that of the rest of the population. The professional diseases do not create a major problem either from the point of view of general health or from the epidemiological point of view. (WHO, 228)

(5A) (HEALTH STATUS OF CHILDREN IN A SOCIETY PLACING HIGH PRIORITY ON CHILDREN'S SERVICES)
The average health status of children and adolescents does not differ significantly from that in other countries with similar standards of living. (WHO, 228)

(5B) Particular attention has been paid to mother and child care. Over 92% of all deliveries take place in hospitals and 100% take place under the supervision of a qualified physician or a midwife. The system of care includes periodical tests and examinations in pregnancy and after delivery. Health care is the most important activity in the care of children and adolescents, starting with examinations of the newborn and continuing with tests at 2,4,6,10,14, and 18 years of age, covering over 90% of the population in these age groups. School clinics have been established in nearly all schools, and in over 80% of school clinics there are a physician and a dentist. (WHO, 231)

(6) (SOCIAL SERVICE WORKERS)
The majority of social service workers are voluntary unpaid workers. In 1976 there were 57000 of them. The social welfare development policy is directed towards increasing the number of qualified social workers so that every primary health care unit, both urban and rural, can employ one. (WHO, 229)

(7) (INTEGRATION OF HEALTH INSTITUTIONS)
In the years 1973-1975 some significant changes in the organization and structure of the institutions subjected to the Minister of Health and Social Welfare were made. The hospitals, outpatient clinics, ambulance units, nurseries and homes for the elderly which had hitherto been separate entities were integrated into centres under one board of directors. Social services were included in the scope of activities of the centres. (WHO, 229)

(8) (HEALTH CARE TEAM)
Primary health care is provided by general practitioners, paediatricians and stomatologists and gynaecologists employed in local outpatient units or clinics, occupational health clinics and village health centres. It is closely linked with social welfare - in every medical clinic there is an environmental social welfare unit. The team, consisting of a general practitioner, a nurse and a social worker, covers the

3000-5000 people in a region. Another team, consisting of a paediatrician and several nurses, takes care of children and adolescents. A third, consisting of a gynaecologist and a midwife, ensures that all pregnant women and those who suffer from diseases of the genital organs receive special care. An additional team of stomatologists and prosthetic surgeons provides preventive, therapeutic and prosthetic dental services. (WHO 230)

(9) WORKPLACE HEALTH CARE

Health care in the work-place is also part of primary care, covering over 6.3 million industrial workers, including transport and building industries.

(10) CONTINUING MEDICAL EDUCATION

The constant progress in science and technology, and the need for continuously raising the level of health care services, forces health service personnel to continue their training in postgraduate studies which are organized by the centre for postgraduate medical education (for all high-school graduates wishing to obtain first and second-degree specializations as physicians, dentists, pharmacists and some other categories) and the centre for post-diploma training of intermediate medical staff. Medical academies and voivodship centres for postgraduate training also conduct such courses. Some 70% of physicians are first- or second-degree specialists. (WHO, 230)

(11) DEMOGRAPHIC CHANGES IMPACT LIFE EXPECTANCY BY 1982

A. The higher death of middle aged men resulted in a decline in life expectancy at birth by 1.3 years to 66 years per male; by 0.6 years to 74.4 years per female. This took place after years of progress in increased life expectancy. (The higher death rate of middle aged men has contributed to this decline in life expectancy) (Webster, 904)

B. Also, there was an expansion in elderly hospital beds. "The number of places in chronically ill also increased considerably. The most rapid increase was in the years 1971-1977, when hospital beds increased by 28,800 to equal the European average." (Webster, 231)

3.2 VITAL DATA AND STATISTICS ON POLAND AS COMPARED WITH OTHER INDUSTRIALIZED NATIONS

The following 1974 and 1975 data show Poland's vital statistics compared to those of other industrialized nations (Kahn, 21-22)

Table 2.1. Population and Area

	Canada	*U.S.*	*U.K.*	*France*	*F.R.G.*	*Poland*	*Yugoslavia*	*Israel*
Total population (in thousands)	22,125 (1973)	211,639 (1974)	56,080 (1974)	52,507 (1974)	62,041 (1974)	33,361 (1973)	20,956 (1973)	3,200[a] (1975)
Area—surface (1,000's sq mi.)	3,852	3,615	94	211	96	121	99	8[b]
Population density per sq mi	6	57	592	247	647	278	210	400[c]
World rank by size	2	4	70	44	68	59	67	132[c]
World rank by population	29	4	12	14	8	20	30	94[c]
Urban population (% of total)	78.0 (1975)	75.0 (1975)	78.0 (1975)	76.0 (1975)	83.0 (1975)	57.0 (1975)	39.0 (1975)	84.0[d]
Average household size (persons)	3.7 (1967)	3.2 (1970)	2.9 (1971)	3.1 (1968)	2.7 (1972)	3.4 (1970)	3.8 (1971)	3.8[e] (1971)
Birth rate per 1,000 population	15.7 (1973)	15.0 (1973)	13.9 (1973)	16.5 (1973)	10.2 (1973)	17.4 (1972)	18.0 (1973)	27.8[e] (1972)
Fertility (per 1,000 females ages 10-49)	52.1 (1973)	50.9 (1973)	57.3 (1973)	61.6 (1973)	42.1 (1973)	55.9 (1972)	58.9 (1973)	95.1[e] (1972)
Death rate per 1,000 population	7.4 (1973)	9.4 (1973)	12.1 (1973)	10.7 (1973)	11.8 (1973)	8.0 (1972)	8.7 (1973)	7.2[e] (1972)
Infant mortality	16.8 (1973)	17.6 (1973)	17.2 (1973)	15.5 (1973)	22.7 (1973)	28.5 (1972)	43.3 (1973)	22.1[f] (1972)
Life expectancy at birth (M)	68.7 (1965-67)	67.4 (1972)	68.7 (1973)	68.5 (1971)	67.4 (1970-72)	66.8 (1972)	65.6 (1971-72)	70.1[g] (1972)
Life expectancy at birth (F)	75.1 (1965-67)	75.1 (1972)	75.0 (1973)	76.1 (1971)	73.8 (1970-72)	73.7 (1972)	70.4 (1971-72)	72.8[g] (1972)
Percent of population 65 and over	8.1 (1971)	10.1 (1971)	13.4 (1972)	13.1 (1972)	13.4 (1972)	[illegible] (1970)	8.3 (1970)	7.3[h] (1975)
Rate of population increase	1.2	0.9	0.3	0.9	0.7	0.9	1.0	3.3[i]

a. *Statistical Abstract* 1975, *Statistical Yearbook* 1975, *U.K. in Figures*, *World Social Report* 1974
b. *Statistical Abstract* 1974
c. *Statistical Abstract* 1975
d. *World Social Report* 1974—some estimates
e. *U.N. Statistical Yearbook* 1974
f. Ibid.; *U.K. in Figures*
g. *U.N. Statistical Yearbook* 1974
h. *World Social Report* 1974. Israeli data reported differently
i. *U.N. Statistical Yearbook* 1974. Figures increase from 1970 to 1974

(Kahn, 21)

Table 2.2. Income, Employment, and Social Conditions

	Canada	*U.S.*	*U.K.*	*France*	*F.R.G.*	*Poland*	*Yugoslavia*	*Israel*
GNP per capita (dollars)	5,650 (1974)	6,600 (1974)	3,260 (1974)	5,230 (1974)	6,180 (1974)	2,050 (1974)	1,320 (1974)	2,618[a] (1974)
Economically active as % of population	40.9 (1971)	44.1 (1974)	46.3 (1971)	42.6 (1975)	43.9 (1974)	52.0 (1974)	43.3 (1971)	32.9[b] (1974)
Female workers as % of female population	44.5 (1971)	46.0 (1970)	52.0 (1971)	44.0 (1968)	46.0 (1970)	66.0 (1970)	44.0 (1971)	34.0[c] (1974)
Female workers as % of labor force	35.0 (1971)	38.0 (1974)	37.0 (1971)	37.0 (1975)	37.0 (1974)	46.0 (1974)	36.0 (1971)	32.0[b] (1974)
Average work hours per week	38.4 (1975)	39.4 (1975)	44.0 (1974)	41.8 (1975)	40.4 (1975)	41.8 (1970)	45.2 (1974)	41.0[b] (1975)
Average persons per room	0.7 (1967)	0.6 (1970)	0.6 (1971)	0.9 (1968)	0.7 (1972)	1.4 (1970)	1.4 (1971)	1.5[d] (1971)
Percent residences with flush toilet	92.5 (1967)	96.0 (1970)	98.9 (1971)	51.8 (1968)	94.2 (1972)	32.9 (1970)	26.5 (1971)	[d]
Telephones per 100 population	52.8	65.7	34.0	21.7	28.7	6.7	4.8	20.8[e]
Education expenditures per capita (dollars)	155.02	188.55	93.31	70.30	64.90	53.94	21.22	65.94[f]
Education expenditures as % of GNP	6.3	5.3	5.1	3.7	3.4	5.5	4.7	4.6[f]
National health program coverage (%)	99.0	10.0	100.0	98.0	90.0	99.0	100.0	85.0[g]

a. Data from U.S. Government Services
b. *I.L.O. Statistical Yearbook*, 1975
c. Ibid.; ages are 15-64 for all but Israel, which covers 14-64
d. *U.N. Statistical Yearbook*, 1974
e. *Statistical Abstract of the U.S.*, 1974; *U.N. Statistical Yearbook*, 1975
f. *World Handbook of Social Indicators*. All data 1971 except Israel and U.K. which are 1970
g. Compiled by various sources in *Social Security Bulletin*, January 1976, p. 43. Covers both insurance and national health service (U.K.). Israeli program administered by trade unions covers only "economically active" and their dependents. U.S. includes only Medicare
(—) Signifies data not available to us

(Kahn, 22)

3.3 USE OF TRADITIONAL HEALTH HEALERS AND PAID PRIVATE PHYSICIANS

In Polish society the use of traditional healers continues especially by the elderly, and people seek assistance outside the system.(Ostrowska, 635)

> The lack of deeper psychic contact between patient and physician particularly in the nationalized health service, on one hand determines patients to look for the private, paid contacts with a physician (or arouses their willingness to pay or to endow a theoretically free of charge physician in return for a better service) on the other hand it creates the climate favorable for the activities of all kinds of healers who simply resolve the entire therapeutic process into a very personal, emotional contact, creation of a specific atmosphere around a healer and a person being healed... The elderly people used this help more frequently, but no differences are seen between urban and rural populations, various educational or socio-occupational groups.

3.4 PROBLEMS OF HEALTH IN POLAND

Drug Abuse was only a minor problem in Poland in 1978 (Marek, 43)

> The abuse of drugs in Poland, a lesser problem than that of alcoholism, has only recently become a subject of interest. Although at present it is not of crucial importance in the pathology of social life, it may still have serious effects on the individual and society.

In 1982, Webster noted that alcoholism, a chronic problem in Poland had dropped by 25% from 1980-81. The rationing of alcohol was probably the major reason. In addition, poisoning from alcohol substitutes was increased and drug related problems from polish heroin increased as well. (Webster, 903)

Air pollution and smoking however have been more substantive problems. This was reflected in anti-smoking Legislation in Poland in 1974 (Pregowski, 149)

> The struggle for the right to unpolluted air to breathe in Poland has its constitutional basis; for this reason, the Social Committee Against Smoking, which has been active since 1946, together with the Group to Fight Against Smoking at the Polish Academy of Sciences, were in 1974 able to secure an official Enactment of the Minister of Health and Welfare entitled "In regard to restrictions of smoking for health reasons" (which regulated smoking in certain public places)

3.5 NUTRITION IN POLAND

Nutrition in 1974 had improved over that of the post W.W. II period but still had a way to go for both children and workers. In 1974, Szczygiel reported cases of child malnutrition in Poland (Szczygiel, 21)

> As the standard of living has been on the rise, nutritional status in general became more and more satisfactory, but still there is a certain percentage of children whose nutritional status is questionable. The reasons for that state of things are mainly socio-economic in nature. In these cases the corresponding bodies have been notified about the needs and possibilities of improving alimentation.

Szczygiel also reported on the need to improve the nutritional level of workers (101)

> From experience gained in this field the following can be mentioned: as a rule, the people working in the open air and in hard conditions are entitled to receive hot meals at a very low price during working hours. As mentioned above, the consumption of vegetables and fruits among industrial workers as very low. During our research on the nutrition of the group of building trade workers, hot meals prepared in the experimental canteen of the Institute of Food and Nutrition according to own recipes were introduced: this substantially increased their consumption of vegetables. In about 30% of the group of workers examined who had these meals, the only vegetables consumed the day of the investigation were those contained in meals supplied by the Institute.

PART IV - PROBLEMS AND ISSUES OF HEALTH CARE

4.1 BASIC NEEDS

The basic health needs of water, nutrition, sanitation, health education, immunization, first aid, on-line diagnosis and referral seem to have been met in Poland. There are however problems in Poland's health system of the types Elling notes (Elling, 95) which can be found in nearly all countries - a sort of convergence of problem areas.

In 1982, Millard saw a worsening and deterioration of Polish health service which he related to a weak Ministry of Health (Millard, 497)

> During its first twenty years the Polish health service represented a neglected sector of government activity, as the development of heavy industry remained the predominant economic goal, with social policy regarded as a "nonproductive" sphere. When Edward Gierek came to power in 1970, the promise of reform extended throughout society to include health. However, despite a fundamental organizational reform, the health service has remained in a state of crisis, currently worsening as a result of mounting economic dislocation and political tension. Inadequate access to treatment, lack of continuity of care, poor quality of care, profound shortages of drugs and supplies, and the absence of preventive medicine are some of the manifestations of this crisis. Its main causes lie in the political weakness of the Ministry of Health, with consequent underfunding and the nonfulfillment of its plans. This situation is exacerbated by continuing organizational fragmentation, the neglect of primary care, the existence of conflicting aims in health policy, and the dominance of an ideology of clinical specialism.

4.2 MALDISTRIBUTION

MALDISTRIBUTION - RURAL/URBAN

Elling notes a general, "rural urban maldistribution of health personnel and facilities in all nations." (Elling, 96). This appears to be a problem in Poland as well.

Despite a well planned system, by 1980, "the problems of maldistribution were widespread - in staffing, hospital beds, outpatient services, and primary care.

Contrary to stereotypes about nationalized health services, getting physicians to rural areas and keeping them there pose difficulties not only in the United States but also in Poland, China, the Soviet Union, the United Kingdom, Sweden, and Africa." (Webster, 310)

Polish physicians, 70% of whom are trained in a specialty, "... much preferred hospital posts and usually preferred urban life." (Webster, 310) The requirement that Polish doctors serve in small towns for 3-5 year periods was dropped around 1956 when the liberalization of Gomulka came into effect. In 1980, there were financial incentives of up to 25% of salary to get doctors to move to small towns. Evidentally, this was not too effective either. (Webster, 311)

MALDISTRIBUTION - POLYCLINIC/HOSPITAL

Elling also notes a persistent problem in most health systems of "inadequate coordination and integration between different authorities

providing health services in the same geographic area" (Elling, 95) Maldistribution also pertains to resources in Poland with hospital bed shortages resulting from changing needs (mental hospitals and tuberculosis sanitoriums) to changing population distribution in spatial location as well as age groups.

Outpatient or polyclinic service areas as opposed to traditional reliance on hospitals, a strong feature of the Polish regionalization system, has not attracted adequate physicians to that type of work. (Webster, 311)

> ...health administrators ... bemoaned the difficulty of attracting physicians to such work. Young physicians (after high school and six years of medical school and internship) were relied on heavily to provide outpatient and primary care, but they took outpatient positions and remained in them mainly when hospital posts were not available. Often, they provided outpatient services on a part-time basis, as a second job or as part of a full-time position. Private practice was uncommon and always part-time. All physicians in Poland held a full-time government post, working 35 hours per week plus every fourth Saturday - until the six-day week every week was restored by martial law, in a return to pre-Solidarity conditions for all workers.

In 1982, Millard noted (Millard, 509)

> In Warsaw, with a national high of 37.1 doctors per 10,000, the Parliamentary Health Commission estimated that about one-third worked in primary care, providing 87 percent of medical services. The number of doctors in rural health centers has been declining in numerical terms over the past few years, although the ratio has remained steady at 2.3 per 10,000, with a high of 3.5 for Lodz and a low of 1.7 in Szczecinskie and Leszczynskie. The main strategy for dealing with the uneven distribution of personnel has been to devise incentives to encourage migration, including higher salaries, housing, and assistance with buying or running a car.

4.3 PHYSICIAN IMBALANCE, STATUS

There is a physician imbalance with high specialization but inadequate physicians in primary care (a similar problem exists in the U.S.A.). "Primary care is the last choice of medical students. This physicians imbalance, (Webster, 311)

> ... was being partly corrected by the government's financial incentives for primary-care practice, particularly in industrial health-care settings. A young general practitioner whom I met in Gdynia took his post at the local shipyard's health unit mainly to meet the financial needs of his new and growing family. He saw 40 patients a day, about half of whom were seeking a certificate for sick leave from work. Alcohol problems were common, he said, but he did not consider himself trained to handle them.

In 1982, the specialist care sector focusing on hospital care absorbed, "... a disproportionate share of health resources in Poland. Generally specialists absorbed about 80 percent of resources, yet they provided less than 20 percent of health care. Nonetheless, the specialist sector, too, suffered acutely from many of the problems evident in primary care. Patients experienced difficulties of access to specialist consultation. (Millard, 511)

The issue of higher doctor status for specialization and lower status for primary care has been a problem in Poland as well as the U.S.A. (Millard, 511)

> Although party and government policy defined the primary care physician as the linchpin of the system, in practice structural change reinforced the hierarchy of medicine. This hierarchy is matched by a pronounced status consciousness, with primary care generally held

> in low esteem. Polish sociologists have consistently drawn attention to this problem, which makes itself felt inter alia in the high turnover of doctors in the primary care sector. The view that primary care is unrewarding also permeates the Medical Academies. In Lodz, for example, a 1978 survey of career goals found that 87.7 percent of final-year students aimed at a specialized, hospital-based career. Only 5.6 percent wanted to work in urban or rural primary care clinics.

The issue of Doctor status also has been impacted by the democratization and political ferment of the solidarity period, and role changes in service delivery. Greater importance for other members of the health team in hospitals, was challening the relative importance of the physicians role. (Webster, ?)

> Polish physicians, who were still in a relatively comfortable hierarchical position in 1981, had already begun to find themselves in a new relation to professions such as nursing, social work, and auxiliary care, as well as to nonprofessional staff. Some hospital directors and university officials had been voted out rather swiftly by rank-and-file personnel. For example, votes in nine mental hospitals changed eight of their directors. In the spurt of self-organization, generation gaps appeared. Older Poles found themselves opposed or deposed by a younger generation - even elders devoted to public service and committeed over the years to the essential causes that Solidarity represented. New competition and factions emerged in local groups and in institutions, including hospitals, medical academies, and health organizations. The distinction between appropriate professional authority and organizational hierarchy came sharply into focus.

Millard notes the changing stratification in health resulting from the impact of solidarity. (Millard, 513)

> Certainly the nature of participation changed during the "Solidarity months," with both Health Solidarity and the ZZPSZ involved in constant negotiations with governmental, ministerial, and provincial authorities. Ad hoc commissions, committees, groups of "experts," working parties, and discussion groups were in continous session, dealing with a vast agglomeration of issues. Agreement had been reached in principle on the reform of the primary care system, to include the choice of family doctor and the assurance of a comprehensive network of adequately supplied facilities; on a Charter of Rights for Health Workers; on a new statute governing the health service. Proposals also were scheduled on the feeding and accommodation of workers, improving the supply of surgical instruments, the reform of dental care, the extension of bacteriological laboratories, and a new Public Health Statute, to give but a few examples.

The problems of cultural inconsistency are noted by Millard. He suggests that the Polish health service has (Millard, 511)

> ... three competing, albeit overlapping sets of ideas: (a) that primary care should be the central focus of health provision; (b) that clinical specialism is all important; and (c) that the problems of the health service are problems of excessive bureaucratization and inefficient management. The underlying issues provided a continuous topic of debate and controversy in the period between the "hot summer" of 1980 and the declaration of martial law in December 1981.

4.4. ADDITIONAL PROBLEMS AND CONCERNS

4.4.1 OPERATIONAL PROBLEMS OF HEALTH SERVICES

The population attitudes on problems of health services in Poland reflect the types of attitudes found in other industrial societies as well. This doesn't support a theory of convergence, but does suggest that ideology is not the main factor in delivery of health services in Poland. Critical population attitudes towards health care are noted by a prominent Polish medical sociologist. (Ostrowska, 635)

> ... The critical remarks on the functioning of health have been focused primarily on the organizational work in outpatient clinics which becomes worse and worse - a long waiting time, inefficency of the personnel, too little time left for examinations and minor treatments, obligatory registration numbers, etc. - 22% of the respondents. The next most frequently criticised factor was the ethics of the medical personnel. According to one-quarter of the respondents believing in the deterioration of the health service in our country, deterioration is said to be due to the medical personnel's inappropriate attitude towards patients, lack of interest in the ill, its corruptibility and a profit-oriented attitude, particularly among physicians (the opinion expressed by 12% of the respondents). A considerable number of the respondents point to the still inadequate availability of the health service - an insufficient number of doctors in particular - in comparison with ever increasing demands.

The Polish people also indicated in a survey a number of weak points in their health system. (Ostrowska, 635-6)

> ... the most frequent reaction to an illness was to neglect its symptoms for as long as possible. Only 15% of the respondents used to undergo preventive examinations on their own initiative. Such a state of affairs seems to be, to a great extent, due to the deficiencies in the functioning of medical care service, which often

compel the patient-to-be to treat problems of health and illness with nonchalance. The data on this subject have been supplied above in the part on the availability of health service. Yet some individual variables had a considerable influence here as well. We have noted a distinct improvement of health culture together with a higher level of education. It was marked, first of all, by a better medical knowledge, a more frequent rational attitude towards the perceived illnesses and care over one's health as well as more demanding expectations of the received medical services.

4.4.2 In 1982, inadequate medical supplies also was a problem in Poland. (Webster, 311)

Poland's health-care concerns were aggravated by great shortages in drugs, medical equipment, and current medical equipment, and current medical literature. Indeed, the acute shortage of drugs, such as antibiotics for children, insulin, and antitubercular medicine, was a key issue in Solidarity's health demands. At one negotiating session the week before my visit to Solidarity headquarters in Gdansk, a spokesperson reportedly said, "If you don't start to produce more medicines, 700,000 people will die for lack of medication in Poland this year." I was unable to verify the statistic, but throughout Poland I heard of many cases that could make it plausible.

Hospital care supplies in Poland could have been better in 1982

(Millard, 511)

Those in hospital endure a total lack of privacy in conditions of extreme overcrowding. Inadequate supplies of soap and disinfectant, lack of laundry facilities, lack of efficient means of rubbish disposal, and shortages of cleaning staff create real difficulties in the maintenance of even basic levels of hygiene. Hospital infection is a serious problem, exacerbated by shortages of sterilizing equipment and such items as disposable needles.

In addition, in 1982, Webster reported that renal dialysis is probably inadequate. In Gdansk, Webster found that only 10% of patients with chronic renal failure were being placed on renal dialysis and that there was inadequate and obsolete equipment. (Webster, 904)

CONVERGENCE OR DIVERGENCE

4.5 Is there convergence of health care systems in different nations due to modernization and technological change? It would seem there is a degree of convergence for communist societies based on a common hegemony.

Weinerman reported in 1968 there were certain strengths characteristic of East European health systems. These were (Weinerman, 276)

1. Delivery of health services to the full population
2. The concept of regionalization

   ... the method of allocation of function among the various echelons of administration. Policy, planning and program standards are developed at the national level; regional coordination of resources is accomplished by the provincial and municipal authorities; the actual provision of services and operation of individual facilities is essentially a district or local concern.

3. ... the formal unity of preventive, therapeutic and educational services within the administrative aegis of the official department of health. Thus, medical care, environmental sanitation, management of special institutions, training of auxiliary health personnel, and control of drugs and medical supplies are jointly the responsibility of the single health authority in each of the main governmental jurisdictions.
4. The emphasis given to the health protection of workers, mothers and children
5. The delineation of the local health community within which basic medical care services are provided.

Mechanic thinks there is a convergence taking place in medical care organizations and systems of modern nations. He contend this convergence is occurring despite political and ideological differences (Mechanic, The Comparative Study... 43)

> An examination of the available descriptive materials on health care delivery systems in various countries throughout the world suggests that the demands of medical technology and the growth of the science base of medical activity produces pressures toward common organizational solutions despite strong ideological differences... As populations increasingly demand medical care, there is growing concern among nations to provide a minimal level of service to all and to decrease obvious inequalities in care. In order to efficiently and effectively use available technology and knowledge, certain organizational options are most desirable. Thus one finds that there is a general tendency throughout the world to link existing services to defined population groups, to develop new and more economic ways to provide primary services to the population without an overelaboration of technological efforts, to integrate services increasingly fragmented by specialization or a more elaborate division of labor, and to seek ways to improve the output of the delivery system with fixed inputs. The hypothesis of convergence does not imply that medical systems, which develop out of the particular historical and cultural background of a nation and its dominant ethos, will not continue to have distinct cultural and social characteristics reflecting the ideological orientations and the sociocultural context of a country. But the basic pattern of practice in modern society is increasingly dominated by the imperatives of the emerging technology, the objective pattern of morbidity in the population, and growing public expectations which are a world phenomenon.

Mechanic also notes that (Mechanic, 244)

> There are at least five major points of convergence: (1) greater emphasis in all countries on ensuring a minimal level of services to all and in decreasing inequalities in the availability of health care; (2) greater emphasis on linking the organization and distribution of services to defined populations; (3) developing new forms of delivering primary medical care; (4) attempting to integrate the fragmented parts of health services; and (5) improving the efficiency and effective operation of the health services system.

Roemer feels this convergence is reflected in the general trends in both Poland and the United States.(Roemer, 162)

> Despite the obvious differences, it seems that American health service is moving in a direction similar to that of Poland, although at a very much slower pace and with numerous variations in detail. If so, the reasons are probably to be found less in the transmission of Polish ideas across the Atlantic Ocean than in the forces that seem to be changing the shape of health care systems in all countries. They are arising from the demands of people to make equal access to health care, in the words of the United Nations, "a basic human right."

Elling however suggests that Roemer and others who focus on this theory of convergence, notes that one should view the systems from a conflict rather than convergence perspective. (Elling, 84-85)

> ... there are theories which see health systems in their contexts, but do so without recognizing that everything is always at issue, always in the balance. Instead of seeing the political-economic structure as dynamically embracing conflicting forces, reflecting the exploitation of working and peasant classes by the ruling class, through their control over the means of production, as mediated by a cultural hegemony, backed up by the political and military power of the state, nations (sometimes all nations, sometimes industrial ones) are seen as more or less functional social-economic units evolving toward a more complex division of labor with greater production and sharing of wealth such that class antagonisms disappear. This is the "end of ideology" ideology of ruling class apologists such as Daniel Bell and others. If one allowed oneself to be mystified by this conception, one could wonder what all the shooting in the world is about. Could it be just some terrible mistake, instead of reflecting the capitalist system's struggle for survival in an increasingly revolutionary-minded world?

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ABSTRACT

HEALTH CARE AND SOCIAL SERVICES IN THE PEOPLES REPUBLIC OF POLAND

by

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American educators often are formally and informally involved in some dimensions of health care services. To provide a perspective on the American system, it is helpful to be aware of the integration of services with the school and the centralized delivery system of a Communist society. Health Care and Social Services in Poland are affected by the culture context of geography, demography, and culturally induced expansion in historical periods. Health and financing of health services are issues with significant political ramifications, and despite egalitarian ideology, there is differential access to care and services. The organization and administration of health care and services includes centralization of policy and financing, as well as regionalization of services. Private health care co-exists with the public sector. Health care data on Poland is given in this document as well as problems of health and nutrition. Issues of health care include meeting basic needs, maldistribution, physician imbalance, operational and supply problems.